ABSTRACT

SOCIAL WORK

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A STUDY OF ATTITUDES OF BLACK MALES TOWARDS THE USE AND ATTENDANCE OF TWELVE-STEP PROGRAMS

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This study was conducted using a survey research design to examine the effects of attitudes of black males on their use of Twelve-Step Programs. Seventy recovering black men who attend Twelve-Step meetings were surveyed. A scale was designed to measure the dependent variable, use and attendance of twelve-step meetings and the independent variable, attitudes of black males.

Pearson's "R" was used to test the relationship between the dependent and independent variables. Results indicated that there was a significant relationship between attitudes and the use and attendance of Twelve-Step groups. The research hypothesis that attitudes effect black males use of Twelve-Step meetings was proven. Therefore, the hypothesis was accepted.

A STUDY OF ATTITUDES OF BLACK MALES TOWARDS THE USE AND ATTENDANCE OF TWELVE-STEP PROGRAMS

A THESIS

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CHAPTER ONE

INTRODUCTION

The devastating impact of addiction on the individual can be seen in every segment of society. Addiction is a disease which encompasses many different unhealthy, obsessive, compulsive, and self-destructive behaviors. Addictive behaviors range from the use of mood changing, mind-altering chemicals such as alcohol, cocaine, heroin, nicotine, caffeine and marijuana, to activities such as over and under eating, gambling, sex and abusive relationships. When left untreated addiction usually results in the deterioration of major areas of life. These areas are generally categorized into financial, health, family, legal, emotional, social and spiritual.

The erosive nature of addiction can be readily identified in black males due to their high rate for predisposition to this disease resulting from the stress of racism and their relationship with American society. Alcohol related problems are considerably higher among black than among white men in the United States. In 1981, it was reported that non-white males in the 25-34 year age bracket who lived in seven major cities were 10 times more likely than white men to die of liver cirrhosis. By 1980, esophageal cancer had become one of the leading causes of cancer death among blacks, with the rate among black males under age 55 exceeding that of whites over sixfold.

Statistics show that black men were overrepresented in mental hospital admissions for alcohol related diagnosis and in arrest for public drunkenness.[1]

Recent studies show that socioeconomic status influences the potential for substance addiction. The lower the socioeconomic status, the higher the chances for addiction. Black males in the lowest socioeconomic status are most likely to fall out of the employment system and engage in substance abuse.[2] Blacks living below the poverty line increased from 8.6 million to 9.4 million between 1980 and 1988.[3] This situation leaves large numbers of black males in a position without medical insurance or the ability to pay out of pocket for medical cost.

The only way to reverse the negative effects of addiction is to establish abstinence and give the individual an opportunity to enter the process of recovery. Frequently, abstinence is accomplished with medical detoxification, a service that can usually be acquired at

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[1]Denise Herd, Ph.D., "Predicting Drinking Problems Among Black and White Men: Results From a National Survey," Journal of Studies on Alcohol (January 1994): 61.

[2]National Institute of Drug Abuse, "Substance Abuse Among Blacks in the United States," in National Association of Alcoholism and Drug Abuse Counselors, Study Guide on Addiction Counseling (Lexington: National Association of Alcoholism and Drug Abuse Counselors, Fifth Printing, 1993), Module, XLIII.

[3]Ibid., Module 3, XLIII.

little or no cost. Ideally, this is followed by some sort of formal treatment. However, for many black men, after detox there is no opportunity for further treatment due to the inability to access a higher level of care.

This is a critical point where alternative ways of maintaining abstinence must be recommended. Twelve-Step fellowships are a valuable option that are cost free and have no admission criterion with them. Twelve-Step programs are generally considered by the professional treatment community as a viable resource for individuals motivated to try and maintain abstinence.

The process of establishing and maintaining recovery from substance addiction is very illusive for black men. Accomplishing recovery is contingent on the ability to remain abstinent from all addictive substances on a daily basis. Successful recovery is associated with changing behaviors, thinking and values from those which promote an addictive lifestyle to those which support a recovery lifestyle.

Long-term recovery from substance addiction requires, the individual to transition through several stages in which certain tasks should be carried out. The function of the tasks are to reinforce the behavior of abstaining from substance use, create alternative ways of responding to the addiction, and expand the foundation on which the recovery lifestyle is based. The transformation from active

addiction to stable recovery is gradual and requires a major shift of the way one views life.

The patience, perseverance, faith, hope, courage, and strength it takes to sustain recovery are qualities that are innate to black males. To survive the slave trade, middle passage, Jim Crow, segregation, desegregation, and other continuing manifestations of racism, the black male obviously has all these attributes, and more. However, the entry into abstinence can be so overwhelming that without being given specific tasks to target and aim for, the process of establishing sobriety through 12-step fellowships can appear impossible.

Statement of the Problem

As a black male social worker with a specialty in substance abuse, I have observed a close relationship between long-term recovery and the use and attendance of 12-Step fellowships. In my experience as a substance abuse counselor, I have seen many more unsuccessful than successful attempts at entering recovery. The majority of successes were those individuals who have incorporated the use of 12-step fellowships into their lifestyle. This study will be conducted to examine the attitudes of black males towards attending and using 12-step fellowship meetings.

The challenge of working with addicted clients is that the nature of their condition is over shadowed by denial. Once abstinence is established denial reduction

must take place immediately. It can usually be accomplished while the emotional pain is acutely fresh in the addict's mind. However, after a few days of abstinence and the emotional pain has began to subside, and the thinking starts to change. Denial can return in the form of rationalization, justification and minimization.

This denial based thinking is fostered by an addictive value system which reinforces using behaviors. If the addictive value system is not replaced by an alternative value system, the cycle of addiction goes uninterrupted. This results only in altering the using pattern instead of establishing ongoing abstinence. Twelve-Step recovery offers an alternative value system that leads to behaviors which promote abstinence.

Significance of the Study

Social work practitioners encounter the results of addiction at every level of service both in the public and private sector. Whether providing direct service to clients or indirect service to staff members, practitioners should be aware of the process of moving from addiction into recovery and how that can be accomplished more successfully.

This study will hopefully give a clearer understanding of factors that effect the attitudes held and practiced by black males who are successfully recovering from addiction. This data should be available to counselors and used to enhance treatment effectiveness. Also at any

point in the treatment process, this information can be used to educate, motivate and reduce the denial of a client. Finally, this data by focusing on positive outcomes, can generate cause for hope in an area of practice that has high rates of relapse and failure.

CHAPTER TWO

REVIEW OF LITERATURE

A Theory for Recovery

The process of recovery from addiction is one that is described in many different ways. Recovery can be defined as addicts breaking ties to their addictive lifestyle and bonding to a recovery oriented support group, where individual healing and healthy relationships are practiced and promoted as the norm.[1] Persons new to recovery can learn and practice the skills that will help them bond to a supportive, recovery-oriented community. This bonding is never completed in treatment. It is a lifelong process that begins in treatment and continues throughout recovery. It is a process supported by participation in the supportive environment of organizations like Alcoholics Anonymous and other 12-step programs.[2]

Recovery can also be looked at as a developmental process. The term "development" means to grow in stages or in steps. It is a gradual effort to learn new and progressively more complex skills. A developmental model of recovery means to grow from simple abstinence to a

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[1]Robert Stuckey, "Deconstructing the Enabling System," conference lecture, Sienna Heights College, June 11, 1986.

[2]Fredrick A. Prezioso, "Bonding in Recovery," Addiction and Recovery (January/February 1992): 35-36.

meaningful and comfortable society.[3] The development model is comprised of six stages through which an individual must successfully navigate. The stages are transition, stabilization, early recovery, middle recovery, late recovery and maintenance as presented by Gorski.[4]

Transition occurs when the addiction begins to cause problems that force a new evaluation of the relationship between chemical use and life problems.[5] Tasks during this stage involve recognizing that something is wrong, and becoming motivated to take action towards correction. Then concluding that drugs and alcohol are partially contributing to problems and finally realizing with acceptance that abstinence from using is needed.[6]

Stabilization is the next stage in which recuperation from the physical, psychological and situational damage caused by addiction takes place.[7] Tasks in this stage are recovery from withdrawal, interrupting addictive preoccupation, short-term social stabilization, learning

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[3]Terence T. Gorski, Passages Through Recovery: An Action Plan for Preventing Relapse (New York: Harper and Row, 1989).

[4]Terence T. Gorski, "Recovery: A Developmental Model," Addiction and Recovery (March/April 1991): 11.

[5]Ibid., 11.

[6]Ibid., 12.

[7]Ibid., 12.

non-chemical stress management and developing hope and motivation.[8]

Accomplishment of these tasks leads to the stage of early recovery. During early recovery the tasks are to develop an understanding of addiction, learn to recognize addiction in thoughts, feelings and actions, then accept and proactively interrupt addictive patterns. Also, non-chemical coping skills must be learned and a sobriety-centered value system should be developed.[9]

In the middle recovery stage the focus is on repairing lifestyle damage caused by the addiction. Tasks involved are resolving the demoralization crisis, repairing addiction-caused social damage and building a balanced lifestyle." At this point, a strong foundation in sobriety should be established facilitating deep and lasting lifestyle changes, which include a solid 12-step recovery program.[10]

Late recovery occurs as the result of inability to build a comfortable and balanced lifestyle because of unfinished issues from childhood.[11] The tasks of this stage are to recognize that childhood issues are affecting the quality of recovery, learn about family of origin

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[8]Ibid., 12.

[9]Ibid., 13.

[10]Ibid., 13.

[11]Ibid., 13.

issues, identification of self-defeating patterns, application to adult living and continued lifestyle change.[12]

The maintenance stage is a lifelong process designed to prevent the tendency to relapse into old patterns of thinking, feeling and acting that can set the stage for a relapse to addictive use.[13] Tasks here are to maintain a recovery program, cope effectively day to day, continue growth and development while coping with life transitions and complicating factors.[14]

These developmental periods show a progression from basic to complex recovery task. This progression is from abstinence (learning how to stop using alcohol and drugs) to sobriety (learning how to cope with life without alcohol and drugs), to comfortable living (learning how to live comfortably while abstinent), to productive living (learning how to build a meaningful sober lifestyle).[15]

Dr. Stephanie Brown presented a developmental model of individual recovery from alcoholism based on interviews with Alcoholics Anonymous members. She described four stages cf recovery as active drinking, transition, early

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[12]Ibid., 14.

[13]Ibid., 14.

[14]Ibid., 14.

[15]Terence T. Gorski and Merlene Miller, Staying Sober: A Guide for Relapse Prevention (Independence, Missouri: Herald House/Independence Press, 1986), 84.

recovery, and ongoing recovery.[16] These stages were expanded by Gorski with his developmental model of recovery. Both Brown and Gorski based their theories on Jellinek's disease concept of alcoholism stemming from the medical model. This model placed primary emphasis on "stages" of development of alcoholism and recovery.[17]

The Need for 12-Step Programs

The opportunity to enter recovery is often predicated on the effectiveness of treatment experienced by the addict. Treatment should empower an individual by providing the tools necessary to stop responding to the compulsion to use. The result is that the intensity of the compulsion becomes reduced over time.[18] Often, the time needed for this to take place is longer than the addict can stay in treatment. This suboptimal situation is compounded because diseases of addiction are treated according to the biases of the treatment provider, and not necessarily by well established therapeutic principles.[19]

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[16]Thomas A. Cornille and Mary Hicks, "A Social Network Model of Recovery: Issues in Boundary Reorganization," Alcoholism Treatment Quarterly 10, no. 1/2 (1993): 65.

[17]Ibid., 64.

[18]Craig T. Pratt, M.D., "Addiction Treatment for Health Care Professionals," Addiction and Recovery (September 1990): 17.

[19]Ibid., 18.

The finite influence of treatment coupled with the chronic and progressive nature of addiction call for nonconventional intervention methods. Alcoholics Anonymous (AA) and other 12-step fellowships offer a viable option. AA has the highest reported number of recovering alcoholics of any organization. In 1983, the reported active membership of this international organization was over a half a million in the United States and Canada alone and growing at the rate of 8% each year. It is estimated that the total number who have been involved in Alcoholics Anonymous since its founding in 1935, even as a conservative estimate, must be in the tens of millions.[20]

The AA model of recovery was the result of two alcoholics discovering that they could help each other stay sober and succeed where each on his own would have probably failed.[21] AA addresses living in the fullest sense of the word, without alcohol via a 12-step spiritual program. With its roots in both the Oxford Group and First Century Christian Reform movements, one might place AA in a moral model framework, yet the religious caveats and moralizing are absent.[22] While the moral model talks about choosing

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[20]J. LeBron McBride, Ph.D., "Abstinence Among Members of Alcoholics Anonymous," Alcoholism Treatment Quarterly 8, no. 1 (1991): 113.

[21]Craig T. Pratt, M.D., "Addiction Treatment for Health Care Professionals," Addiction and Recovery (September 1990): 17.

[22]Ibid., 39.

right behavior over wrong, the AA model states that the choice for addicts was not the same as it was for nonaddicts. Addicts have a disease creating different needs and responsibilities in regards to using alcohol and drugs.[23] AA stresses that because alcoholism or addiction is an illness the alcoholic is not responsible for being an alcoholic; however, AA does stress that the alcoholic is responsible for getting well from the illness.[24]

Most present experts in addiction believe that 12-Step groups should be an integral part of treatment and long-term recovery. The prototype for 12-step groups is AA founded in 1935 by Robert Holbrook Smith ("Dr. Bob"), a surgeon and William Wilson ("Bill W."), a stockbroker. Since then, more than 150 parallel groups have been developed, the most prominent of which are Al-Anon, Narcotics Anonymous, Cocaine Anonymous, Children of Alcoholics, and Overeaters Anonymous.[25] Some other 12-Step fellowships are Debtors Anonymous, Emotions Anonymous, Gamblers Anonymous, Incest Survivors Anonymous, Nicotine Anonymous, Obsessive-Compulsives Anonymous, Prostitutes

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[23]Ibid., 39.

[24]Cynthia Downing, Triad: The Evolution of Treatment for Chemical Dependency (Independence, Missouri: Herald House/Independence Press, 1989), 25.

[25]Peter N. Johnson, Ph.D. and John N. Chappel, M.D., "Using AA and Other 12-Step Programs More Effectively," Journal of Substance Abuse Treatment 11, no. 2 (1994): 137.

Anonymous, Racism and Bigotry Anonymous, Sexaholics Anonymous, Smokers Anonymous and Workaholics Anonymous.[26]

In 1957, the American Medical Association designated alcoholism as a disease, it did the same for other drug addictions in 1987. A prospective study by Vaillant in 1983 attributed 7% of the variance of good clinical outcome in recovering from addiction to "stable adjustment, married, employed, never detoxified" but 28% of the variance to attendance at AA meeting (over 300 meetings). This shows that AA is more important over the long term than professional treatment.[27] This assertion had been presented decades before by Dr. William Silkworth, a physician who worked with alcoholics before and after AA was founded in a letter he wrote concerning his work with Bill W., one of AA's co-founders.

"In the course of his treatment, he (Bill W.) acquired certain ideas concerning a possible means of recovery. As part of his rehabilitation he commenced to present his conceptions to other alcoholics, impressing upon them that they must do likewise with still others. This has become the basis of a rapidly growing fellowship of these men and their families. This man and over one hundred

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[26]Robin Roour and Thomas Greenfield, "Alcoholics Anonymous, Other 12-Step Movements and Psychotherapy in the U.S. Population 1990," Addiction 88 (1993): 556.

[27]Peter N. Johnson, Ph.D. and John N. Chappel, M.D., "Using AA and Other 12-Step Programs More Effectively," Journal of Substance Abuse Treatment 11, no. 2 (1994): 137.

others appear to have recovered. I personally know scores of cases who were of the type with whom other methods had failed completely. These facts appear to be of extreme medical importance; because of the extraordinary possibilities of rapid growth inherent in this group, they may mark a new epoch in the annals of alcoholism.[28]

Dr. Silkworth's written contribution to the Big Book of Alcoholics Anonymous entitled "The Doctors Opinion," gives further indication of his conviction when he states "The subject presented in this book seems to me to be of paramount importance to those afflicted with alcoholic addiction."[29] He goes on in this section to explain the progression of addiction using the medical model while showing how the use of Alcoholic's Anonymous 12-step philosophy was effective in offsetting addictive pathology.

An examination of the historical roots of the 12-Step program will reveal that Alcoholic Anonymous chief architect, Bill Wilson had read William James' classic text, The Varieties of Religious Experiences, extensively. James' philosophical position of pragmatism is a theme which runs throughout Alcoholics Anonymous' program of recovery. Wilson also had extensive correspondence with Carl Jung and

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[28]Alcoholics Anonymous, 3rd ed. (New York: Alcoholics Anonymous World Service, 1976), XXIII.

[29]Ibid., XXV.

Jung's influence is strongly reflected in the spiritual emphasis of the program.[30]

The diverse philosophical and theoretical roots of Alcoholics Anonymous offer some important principles of treatment that are applicable to psychotherapy, both individual and group, and can be used for patients who are not addicted.[31] It is through the telling of their life history that they are taught how to interpret their past in a way that gives meaning to the past and hope for the future.[32] After accepting the program, many claim to have experienced "personality changes" which accompany a new understanding of themselves and of their world. Unlike most medically oriented therapeutic systems, the real problem as AA analyzes it, centers around helping the alcoholic to understand his basic "being" as an alcoholic rather than as normal and non-alcoholic.[33] This approach provides the alcoholic with a commonly shared explanation of his suffering; it helps the alcoholic find meaning in his suffering by providing him a meaningful paradigm for his experience. Involvement in 12-step fellowships facilitates an educational process which allow suffering to be

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[30]Philip J. Flores, Ph.D., "Alcoholics Anonymous: A Phenomenological and Existential Perspective," Alcoholism Treatment Quarterly 5, no. 1/2 (1988): 74.

[31]Ibid., 75.

[32]Ibid., 76.

[33]Ibid., 77.

integrated into a person's life in a meaningful way and trains the addict to be more self-aware and honest with himself. It also assists the individual in achieving more adequate control over his primitive impulses and strivings, along with being freer in expressing his feelings. It also promotes becoming more tolerant of human limitations, developing the ability to postpone, modify and even forego gratifications whose demands previously seemed impervious.[34]

Over the last 60 years, the substance of AA, its core literature, its program of recovery and its ways of looking at life, has changed very little. But in terms of the numbers and diversity of its members, AA today would be unrecognizable to its pioneers. In the early years, AA members were almost exclusively male, white, middle-class, middle-aged and of Western European extraction.[35]

The AA of 1996 is huge, increasingly international, multiethnic, multiracial, cutting across social classes, less rigidly religious than it was in the beginning, more accepting of gay people and women.[36] Although there are black AA groups and mixed racial groups in large Northern cities, the number of blacks in AA does not appear to

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[34]Ibid., 83.

[35]Nan Robertson, "The Changing World of Alcoholics Anonymous," The New York Times Magazine (February 21, 1988): 42.

[36]Ibid., 42.

reflect the race's proportion in the nation, 29 million, or 12 percent of the population.

"There is a great stigma in being black and being an addict or recovering," a black Philadelphia teacher declared at a meeting devoted to the subject. "I made the mistake of telling my principal that I had a problem. I checked myself into a treatment center. She used a hatchet on me." This sentiment was reinforced when a black Milwaukee social worker explained: "The black community is afraid that if blacks admit their alcoholism, it will reinforce the white stereotype that they are shiftless. The black community likes to think that oppression causes their alcoholism. Other oppressed minorities use the same argument. 'Who wouldn't drink?' they say. 'Our lives are so goddamned awful, oblivion is the only way out of the pain.'"[37]

Black Males and Help Seeking

Research shows that 38% of African American men have evidence of alcoholism. In comparison with other ethnic groups, African Americans were less likely to obtain help for alcoholism.[38] These impediments are related to the idea that African American men are unable to attain their

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[37]Ibid., 43.

[38]Carl S. North and Elizabeth M. Smith, "Systematic Study of Mental Health Services Utilization by Homeless Men and Women," Social Psychiatry and Psychiatric Epidemiology 28 (Spring 1993): 77.

full potential due to social, economic, and cultural barriers.

Historically, the African American man has had to fight for his masculinity. A significant number of African American males are born in environments that have high rates of poverty, crime, and unemployment. These factors will influence whether an African American male is able to master developmental tasks that will aid in his success.

Theorists such as Eric Erikson suggest that the development of life stages are dependent on both the environment and heredity. Erikson's psychosocial development theory states that as a person goes through life there are a series of developmental tasks that one must master. Mastery of these tasks at each developmental stage determines success in the mastery of tasks in the next stages. For example, during early development a child must develop trust. For those who are unable to master this task, other developmental tasks are not sufficiently mastered.

It is normal to encounter African American males that have a basic mistrust of their environment, doubts about their abilities, and confusion about their role in society. This role confusion is compounded by the fact many do not have a positive male role model in their immediate environment.[39]

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[39]Ronald B. Mincy, Nurturing Young Black Males:

In a study completed by Pugh and Mudd (1971), African American men indicated that they were unable to trust people. As children they were raised to not go "running for help." The men also reported that they had to appear strong despite their lack of strength. They were more likely to seek help from their mothers, ministers, spouse or father, and informal sources. They also reported that they did not like discussing their personal problems with other people, adding that they should be able to handle their own problems. The severity of the problem would have to be great in order for these men to seek help. They did not believe that other people thought they were important and thus would not help them. To ask for help from others would be a burden on the other person. However, the majority of men in that study reported that if help is sought, it should come from a professional. They listed service fees, the profession, and availability of the helping person as obstacles in their help seeking behavior.[40]

The African American male was taught as a child, to not express himself fully, outside of the African American community. African American families have always had the task of teaching their children how to survive in a

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Challenges to Agencies, Programs, and Social Policy (Washington, D.C.: Urban Institute Press, 1994), 35-36.

[40]Thomas J. Pugh and Emily H. Mudd, "Attitudes of Black Women and Men Toward Using Community Services," Journal of Religion and Health 10 (1971): 261-269.

segregated society. Some of these teachings encouraged children to "(1) expression aggression indirectly, (2) read the thoughts of others while hiding their own, and (3) engage in ritualized accommodating-subordinating behaviors designed to create as few waves as possible." Self-disclosure also conflicts with the African American man's perception of masculinity, thus threatening this strength and power. These defense mechanisms can be mistaken as resistance by social service providers.

African American men's helping network is considered to be less extensive and they tend to seek help from friends versus professional service providers. African American men also report that they would seek assistance from an informal source for a "serious problem." The utilization rate of formal sources by African American males is low. The majority of African Americans that do receive assistance from formal sources are usually mandated by teachers, employer, court system, or social service agency.

African American men tend to not seek help from formal sources such as social workers and counselors. Those that do seek help from professionals are more likely to terminate the services prematurely and usually do not seek help until the problem has reached a level of crisis. This is especially true in cases of substance addiction.

Twelve Step fellowships are an informal resource that offer a less threatening environment. When used in

conjunction with pre- and post-contact with formal professional assistance, 12-step groups can be a valuable primary or secondary means of support.

An issue that is frequently encountered by black males which effects their attitude toward use of 12-step groups is that these groups exclude important personal attributes, such as race, gender or class and pay attention only to the process of recovery.[41] If meetings are not available in the African American community then situations of cultural isolation at meeting may occur. This can result in feeling unwelcome and uncomfortable.

The average African American addicted male has experienced racist attitudes that have left emotional scars. The acknowledgement of this pain without attitudes of indifference, anger, or arrogance is in line with the rigorous self-honesty promoted in twelve-step programs.[42] This acknowledgement can be done one to one with another recovering person or in a meeting setting. To not admit and accept this pain as a cultural difference would be dishonest. Part of the process of recovery is to develop a healthy self-concept and a positive self-image. This is facilitated by attendance to 12-step meetings.

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[41]Peter Bell, "Cultural Pain and African Americans: Unspoken Issues in Early Recovery," Hazelden Educational Materials (1992): 36.

[42]Brenda A. Williams, Tommie M. Richardson, and Donnie Watson, "Recovery for the African American Family," Hazelden Foundation (1991): 17.

More and more oppressed minorities are finding their place in 12-step programs either through closed meetings specifically for a particular minority group or through participating in more open-minded multicultural groups available especially in larger cities.[43] Adoption of the 12-step philosophy places the recovering black male in a community that values (1) the sharing of common experiences, (2) mutual acceptance of one another as human beings, (3) trusting a higher power (God as we understand God). All these are strong elements in the African American culture, and are reinforced by the recovery lifestyle.

The responsibility for long term successful recovery is placed in the hands of the addicted black male regardless of his exposure to formal treatment or the lack thereof. He must meet this responsibility in spite of racism, social discrimination, cultural differences or isolation caused by distance or location. An open and receptive attitude towards the use of 12-step programs is one that has proven beneficial in promoting recovery to a cross section of all cultural groups on a worldwide level. It is hoped that this research will help increase and reinforce the opportunity for recovery in black males.

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[43]Tommie M. Richardson and Brenda A. Williams, "African-Americans in Treatment: Dealing with Cultural Differences," Hazeldan Foundation (1990): 14.

Statement of the Hypothesis

A review of the literature indicates that 12-step groups are effective in facilitating the process of recovery from substance addiction. If the literature is correct, we hypothesize that the more positive the attitude towards the use of 12-step groups by black males, the more likely they are to attend these groups.

CHAPTER THREE

RESEARCH DESIGN

A descriptive comparison group post test only design was used to test the hypothesis. Two comparison groups of men with one year or less of sobriety and men with five or more years of sobriety were used. The objective of this design was to (1) measure attitudes towards 12-step meeting use and attendance of black males with one year or less of sobriety, (2) measure attitudes toward 12-step meeting use and attendance of black males with five years of sobriety or more, and (3) compare the effect of several variables on attitudes towards meeting attendance.[1]

Sample

The population for this study was comprised of 70 black males in the process of recovery from addiction, who attend 12-step fellowship meetings. This population was located in the metropolitan area of Atlanta, Georgia. The samples taken from this population were divided into two groups. Group 1 was comprised of 35 participants with 5 or more years of sobriety. Group 2 was comprised of 35 participants who had one year or less of sobriety. There were no limitations for participation in terms of age, educational level, income, marital status, type or number of

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[1]Richard M. Grinnell, Jr., Social Work Research and Evaluation, 4th ed. (Illinois: F.E. Peacock Publishers, Inc., 1993), 144.

treatments, and if any, or kind of 12-step meetings attended. The sampling method that was employed was a stratified random sampling approach.

Data Collection and Instrumentation

The data collection instrument involved a self-administered questionnaire of 41 questions. Thirteen questions collected demographic variables and 28 questions measured attitude toward meeting use and attendance. Questionnaires were distributed at various 12-step meetings and in a transitional residence. Questions were developed directly from Johnson and Chappel's "Recommendations to Patients."[2] Each recommendation was interpreted as a positive and healthy action therefore implying a positive attitude towards using and attending 12-step meetings. All recommendations that applied to meeting attendance were put into statement form. Each statement could be supported by an answer ranging from strong agreement to strong disagreement. The answer reflected the attitude of the individual filling out the questionnaire.

Data Analysis

Pearson's "R" was utilized to determine the relationship between attitudes and meeting attendance. Chi-square, mean and standard deviation were used to

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[2]Peter N. Johnson, Ph.D. and John N. Chappel, M.D., "Using AA and Other 12-Step Programs More Effectively," Journal of Substance Abuse Treatment 11, no. 2 (1994): 139.

describe the data. The data was coded and analyzed by the use of the Statistical Packages for the Social Sciences.[3]

[3]N. H. Nie, D. H. Hull, J. C. Jenkins, and K. Steinbrunner, Statistical Package for the Social Sciences, 2nd ed. (New York: McGraw-Hill, 1985).

CHAPTER FOUR

PRESENTATION OF RESULTS

Frequency tables were used to illustrate each of the 13 demographic questions. The age range of participants was 22-65 years old with the mean age being 39 years old. Although the sample was divided into two groups even in size, one with a year or less of sobriety and the second with 5 or more years of sobriety, the mean length of sobriety for both groups combined was 1.5 years of sobriety. The shortest length of sobriety in the sample was 12 days and the greatest amount was 29 years and 9 months.

The distribution of educational level indicated 7.1% with some high school, 30.0% high school graduates, 4.3% GED recipients, 44.3% some college, 10.0% college graduates, and 4.3% post baccalaureate education.

There were six ranges that income level was divided into. These ranges went from 0 to 10,000, 11,000 to 20,000, 21,000 to 30,000, 31,000 to 40,000, 41,000 to 50,000, and 51,000 and above. Thirty two point nine percent of the respondents had income levels between 0 and 10,000 dollars a year. Ten percent had incomes between 11 and 20,000 while 14.3% fell between 21 to 30,000. The 31 to 40,000 range held 24.3% of respondents as compared to 11.4 in the 41 to 50,000 level. Only 7.1% of participants fell into the 51,000 and above range.

In terms of treatment experiences 12.9% of respondents indicated never receiving any type of treatment. Twelve point nine percent reported taking part in outpatient treatment while 48.5% had been involved with inpatient treatment. Twenty five point seven percent of the participants had lived in halfway house settings.

The number of times each respondent had been in treatment was measured. It was shown that 20.0% reported never being in treatment, 25.7% reported one treatment experience, 22.9% reported two treatments, 14.3% indicated three treatments and 17.1% had been to treatment four times or more.

The marital status of participants were as follows: 41.4% single, 34.3% married, 2.9% separated, 18.6% divorced, 1.4% widowed, and 1.4% cohabitating. Age of first use was distributed into the five following ranges, age 10 or less made up 24.3% of the sample, age 11-15 was 44.3% of the respondents, 28.6% reported age 16-25, 1.4% showed age 26-35 and 1.4% started using at age 36 or over.

The representation for age of first treatment was 18.6% of the participants entered treatment at the age of 20 or less, 38.6% entered between age 21 to 30, 34.3% entered between age 31 to 40, 5.7% entered between age 41 to 50, and 2.9% entered at age 51 or older.

The frequency of 12-step meeting attendance was broken into the following five ranges: everyday attendance

was represented by 30.0% of the respondents, 2-4 times a week made up 32.9%, 5-7 times a week made up 28.6%, one time a week was 7.1% of participants and 2.9% indicated attendance of less than one time a week.

In terms of the kind of 12-step meeting respondents attend, 48.6% attend Alcoholics Anonymous, 41.4% attend Narcotics Anonymous, 8.6% attend Cocaine Anonymous and 1.4% attend other type of 12-step based meetings.

When asked for their preference of the kind of meeting attended, 45.7% prefer Alcoholics Anonymous, 48.6% prefer Narcotics Anonymous, 2.9% prefer Cocaine Anonymous and 2.8% prefer other 12-step based meetings.

Frequency distribution tables were used to count the number and level of responses to a 28 item questionnaire which measured attitudes towards the use of 12-step fellowship meeting. The number of respondents was 70 and shown in terms of percentages. The level of response was to strongly agree, agree, be undecided, disagree or strongly disagree.

The response to these 28 questions were as follows in Table 1.

TABLE 1

ATTITUDES TOWARD 12-STEP MEETINGS

1. Your attendance at 12-step meetings is necessary in dealing with addiction.

	N	%
a. Strongly Agree	60	85.7%
b. Agree	6	8.6%
c. Undecided	1	1.4%
d. Disagree	1	1.4%
e. Strongly Disagree	1	1.4%
f. Missing	1	1.4%

2. Your attendance at 12-step meetings is a major part of your recovery process.

	N	%
a. Strongly Agree	60	85.7%
b. Agree	7	10.0%
c. Undecided	0	0.0%
d. Disagree	1	1.4%
e. Strongly Disagree	1	1.4%
f. Missing	1	1.4%

3. Your attendance at 12-step meetings can help in your spiritual development.

	N	%
a. Strongly Agree	55	78.6%
b. Agree	12	17.1%
c. Undecided	0	0.0%
d. Disagree	2	1.4%
e. Strongly Disagree	1	2.9%
f. Missing	1	1.4%

TABLE 1 (continued)

4. It is important to understand spirituality in order to use 12-step meetings properly.

	N	%
a. Strongly Agree	36	51.4%
b. Agree	16	22.9%
c. Undecided	3	4.3%
d. Disagree	8	11.4%
e. Strongly Disagree	6	8.6%
f. Missing	1	1.4%

5. Meetings should be attended even if abstinence is not maintained.

	N	%
a. Strongly Agree	46	65.7%
b. Agree	15	21.4%
c. Undecided	3	4.3%
d. Disagree	3	4.3%
e. Strongly Disagree	2	2.9%
f. Missing	1	1.4%

6. It is important to go to 90 meetings in a row.

	N	%
a. Strongly Agree	52	74.3%
b. Agree	12	17.1%
c. Undecided	1	1.4%
d. Disagree	2	2.9%
e. Strongly Disagree	2	2.9%
f. Missing	1	1.4%

7. It is important to keep track of the number of meetings you attend.

	N	%
a. Strongly Agree	16	22.9%
b. Agree	23	32.9%
c. Undecided	9	12.9%
d. Disagree	18	25.7%
e. Strongly Disagree	2	2.9%
f. Missing	2	2.9%

TABLE 1 (continued)

8. Each meeting attended is equivalent to a daily dose of medication for addiction.

	N	%
a. Strongly Agree	37	52.9%
b. Agree	28	40.0%
c. Undecided	1	1.4%
d. Disagree	2	2.9%
e. Strongly Disagree	1	1.4%
f. Missing	1	1.4%

9. It is important to arrive to meetings early.

	N	%
a. Strongly Agree	37	52.9%
b. Agree	27	38.6%
c. Undecided	2	2.9%
d. Disagree	2	2.9%
e. Strongly Disagree	1	1.4%
f. Missing	1	1.4%

10. It is better to not attend a meeting than to arrive late.

	N	%
a. Strongly Agree	2	2.9%
b. Agree	1	1.4%
c. Undecided	0	0.0%
d. Disagree	22	31.4%
e. Strongly Disagree	44	62.9%
f. Missing	1	1.4%

11. It is important to talk to other meeting participants.

	N	%
a. Strongly Agree	46	65.7%
b. Agree	21	30.0%
c. Undecided	1	1.4%
d. Disagree	0	0.0%
e. Strongly Disagree	1	1.4%
f. Missing	1	1.4%

TABLE 1 (continued)

12. It is important to socialize with other recovering people who attend 12-step meetings.

	N	%
a. Strongly Agree	49	70.0%
b. Agree	17	24.3%
c. Undecided	1	1.4%
d. Disagree	2	2.9%
e. Strongly Disagree	1	1.4%

13. There is a therapeutic benefit to stating that you are an alcoholic/addict when speaking as part of a meeting.

	N	%
a. Strongly Agree	45	64.3%
b. Agree	20	28.6%
c. Undecided	3	4.3%
d. Disagree	0	0.0%
e. Strongly Disagree	2	2.9%

14. It is important to listen carefully to each person who talks during the meeting.

	N	%
a. Strongly Agree	48	68.6%
b. Agree	21	30.0%
c. Undecided	0	0.0%
d. Disagree	0	0.0%
e. Strongly Disagree	1	1.4%

15. It is important to plan what you will say at a meeting.

	N	%
a. Strongly Agree	2	2.9%
b. Agree	3	4.3%
c. Undecided	6	8.6%
d. Disagree	41	58.6%
e. Strongly Disagree	18	25.7%

TABLE 1 (continued)

16. Members of the meeting have information you need very badly.

	N	%
a. Strongly Agree	29	41.4%
b. Agree	32	45.7%
c. Undecided	5	7.1%
d. Disagree	3	4.3%
e. Strongly Disagree	1	1.4%

17. You can learn something from every person that speaks at a meeting.

	N	%
a. Strongly Agree	38	54.3%
b. Agree	24	34.3%
c. Undecided	3	4.3%
d. Disagree	3	4.3%
e. Strongly Disagree	2	2.9%

18. It is important to find a sponsor in the first 2 months of attending meetings.

	N	%
a. Strongly Agree	37	52.9%
b. Agree	18	25.7%
c. Undecided	4	5.7%
d. Disagree	7	10.0%
e. Strongly Disagree	3	4.3%
f. Missing	1	1.4%

19. It is important to find a sponsor of the same sex.

	N	%
a. Strongly Agree	39	55.7%
b. Agree	17	24.3%
c. Undecided	4	5.7%
d. Disagree	3	4.3%
e. Strongly Disagree	6	8.6%
f. Missing	1	1.4%

TABLE 1 (continued)

20. It is important to collect first names and phone numbers of individuals of the same sex while at meetings.

	N	%
a. Strongly Agree	41	58.6%
b. Agree	18	25.7%
c. Undecided	5	7.1%
d. Disagree	5	7.1%
e. Strongly Disagree	1	1.4%

21. It is important to call other recovering people who attend meetings to talk about any difficulties.

	N	%
a. Strongly Agree	49	70.0%
b. Agree	18	25.7%
c. Undecided	2	2.9%
d. Disagree	0	0.0%
e. Strongly Disagree	1	1.4%

22. It is important to talk about cravings during meetings.

	N	%
a. Strongly Agree	50	71.4%
b. Agree	14	20.0%
c. Undecided	3	4.3%
d. Disagree	1	1.4%
e. Strongly Disagree	2	2.9%

23. It is important to pitch in with cleaning at meetings by emptying ashtrays and making coffee.

	N	%
a. Strongly Agree	40	57.1%
b. Agree	27	38.6%
c. Undecided	2	2.9%
d. Disagree	0	0.0%
e. Strongly Disagree	1	1.4%

TABLE 1 (continued)

24. If you do not like a meeting, you should not return to one ever again.

	N	%
a. Strongly Agree	2	2.9%
b. Agree	0	0.0%
c. Undecided	2	2.9%
d. Disagree	17	24.3%
e. Strongly Disagree	49	70.0%

25. In treatment, it is important to be required to attend 12-step meetings.

	N	%
a. Strongly Agree	52	74.3%
b. Agree	13	18.6%
c. Undecided	2	2.9%
d. Disagree	2	2.9%
e. Strongly Disagree	1	1.4%

26. It is important to attend same sex 12-step meetings.

	N	%
a. Strongly Agree	14	20.0%
b. Agree	13	18.6%
c. Undecided	9	12.9%
d. Disagree	21	30.0%
e. Strongly Disagree	13	18.6%

27. It is important to attend same race 12-step meetings.

	N	%
a. Strongly Agree	4	5.7%
b. Agree	6	8.6%
c. Undecided	7	10.0%
d. Disagree	26	37.1%
e. Strongly Disagree	27	38.6%

TABLE 1 (continued)

28. It is important to attend same sex and same race meetings.

	N	%
a. Strongly Agree	4	5.7%
b. Agree	7	10.0%
c. Undecided	8	11.4%
d. Disagree	23	32.9%
e. Strongly Disagree	28	40.0%

Cross tabulation was used to rank each 28 item questionnaire on attitudes toward 12-step meeting. The rankings were high, medium or low and determined by a numerical total that was based on the answer given to each item. A score of 28 to 56 shows a positive or high attitude. A score of 57 to 85 shows a moderate or middle attitude. A score of 86 to 104 shows a negative or low attitude.

Of the 70 participants in the study, 45.7% ranked as having positive attitudes, 45.7% ranked as having moderate attitudes, 1.4% had scores indicating negative attitudes and 7.1% could not be classified. The dependent variable of attitudes toward use and attendance of 12-step groups was analyzed to measure if there was a relationship with several independent variables. The independent variables were length of sobriety, income level, educational level, number of times in treatment and how often meetings are attended.

When length of sobriety was correlated with attitudes, 44.1% of men with one year or less of sobriety showed high attitudes and 55.9% showed medium attitudes with none showing low. Men with 5 or more years of sobriety showed 54.8% with high attitudes, 41.9% with medium and 3.2% with low attitudes. The chi-square level of significance was .3471%.

When level of education was correlated with attitudes, 50.0% of men with some high school had high attitudes while 50.0% had medium and none had low. Forty seven point four percent of the high school graduates had high attitudes, 52.6% had medium and none reported low. Participants with GED's showed 66.7% with high attitudes, 33.3% with medium and none with low. Forty eight point three percent of respondents with some college had high attitudes, while 48.3% showed medium and 3.4% indicated low attitudes. College graduates showed high attitudes 42.9% of the time, medium 57.1% of the time and indicated no low attitudes. Participants with post baccalaureate education showed high attitudes at a rate of 66.7%, medium at 33.3% and showed no low attitudes. The chi-square level of significance was .9952%.

When income level was correlated with attitudes individuals making less than $10,000 showed high attitudes 34.8%, medium 65.2% and low none of the time. Individuals with incomes between $11 and $20,000 showed high attitudes

66.7%, medium 33.3% and low none of the time. Incomes of $21,000 to $30,000 showed high 60.0%, medium 40.0% and no low. Incomes of $31,000 to 40,000 indicated 56.3% high, 43.8% medium and no low. Incomes of $41,00 to $50,000 reported 66.7% high, 33.3% medium and no low. Incomes of $51,000 plus showed 25.0% high, 50.0% medium and 25.0% low. The chi-square level of significance was .0300%.

When number of times in treatment was correlated with attitudes, participants with no treatment history showed high attitudes at a rate of 42.9%, medium at 57.1% and no low. Respondents with one treatment showed high 50.0%, medium 50.0% and no low. Respondents with two treatments showed high 40.0%, medium 60.0% and no low. Participants with three treatments indicated 62.5% high, 25.0% medium and 12.5% low. Respondents with four or more treatment experiences showed high attitudes 60.0% of the time, medium 40.0%, and showed no low. The chi-square level of significance was .2879%.

When how often meetings are attended was correlated with attitudes respondent that attended everyday showed high attitudes 50.0% of the time, medium 50.0% and no low. Those attending 2 to 4 times a week showed 47.6% high, 52.4% medium and no low. Attendance 5 to 7 times a week indicated 42.1% high, 52.6% medium and 5.3% low. Participants who went less than once a week showed 75.0% high, 25.0% medium

and no low attitudes. The chi-square level of significance was .7210%.

CHAPTER FIVE

SUMMARY AND CONCLUSIONS

The study revealed that of the five independent variables correlated with attitudes toward using 12-step groups only 2 showed a significant relationship. Length of sobriety, income level, and number of times in treatment showed no significant relationship. However, level of education and number of meetings attended weekly did show a significant relationship to attitudes toward meeting attendance.

In terms of length of sobriety the lack of relationship may be attributed to the fact that positive attitudes towards meeting attendance held in early recovery tend to remain consistent into and throughout long-term recovery. It was surprising that there was no relationship indicated between number of treatments and attitudes toward meeting attendance. However the same premise that applies to the length of sobriety relationship can be placed on number of treatments relationships meaning that multiple treatment failures could imply a negative attitude toward recovery and meeting attendance which is maintained consistently.

The lack of relationship between income level and attitude towards meeting attendance warrants further investigation because income or the lack thereof is greatly effected by addiction. Leading one to believe that the same

would be true for recovery. There are numerous examples of instances where the need to regain income compromised meeting attendance or where the ready availability of income challenged one's perception in terms of their need for meetings.

The significance of the relationship between level of education and attitude towards meeting attendance was that regardless of educational level, high to medium attitudes were maintained. Showing that the emotional pain experienced by the individual entering into is recovery base more importance than their level of intelligence. There is evidence that high levels of intellect can often have a negative impact on the way 12-step meetings are viewed. The ability to grasp concepts presented in 12-step meetings without attaching academic value to it is a relationship that could be studied.

The relationship between how often meetings are attended and attitudes toward meeting attendance is significant in that frequent attendance is correlated with high attitudes. In 21 cases where low attendance was correlated with high attitudes the respondents had 5 or more years of sobriety. This relationship supports the theory that the more a person is exposed to meetings the better their attitude becomes about attendance. It also substantiates the AA practice of going to at least one meeting a day for 90 days in a row.

Finally, the results of this study shows that the black males who participated in this study held, for the most part, positive attitudes towards 12-step meeting attendance. They confirmed that positive attitudes held in early recovery remain consistent into late recovery and that for this group education had no effect on attitude towards meeting attendance and use. This study also establishes the fact that there are at least 35 African American males in the Atlanta metropolitan area that have been sober for 5 or more years by attending 12-step fellowships. This information reinforces the fact that black males of all educational and economic backgrounds can successfully recover with a positive attitude towards the use and attendance of 12-step programs.

Limitations of the Study

The methodological problems involved in the research of 12-step groups is that they are not formal organizations--there are not membership roles or records that show frequency of attendance by individual members. The self selection and motivation of the members make it difficult to know if what is being measured is the therapeutic efficacy of the 12-step program or merely the motivation of its members.[1] Also a large portion of the sample with a year

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[1]J. LeBran McBride, Ph.D., "Abstinence Among Members of Alcoholics Anonymous," Alcoholism Treatment Quarterly 8, no. 1 (1991): 114-115.

or less of sobriety was taken from a structured living situation in which meeting attendance was required. This factor may have influenced some of those respondents' level of answer disclosure. This study was also limited to a major urban setting in the south which could have unaccorded for effects.

Suggestions for Research

A longitudinal study of meeting attendance using multi-variant measures to identify entrenched attitudes found in long-term recovery. Also a study of meeting attendance attitude in various 12-step groups. A comparative study of gender attitudes toward meeting attendance would also provide needed information on factors which lead to successful recovery in 12-step groups.

CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

The process of recovery from addiction is one which all social workers should be knowledgeable of regardless of area of specialization or level of practice. This study has highlighted individuals successfully engaged in this process. It has established that 12-step programs are a valuable resource. They can be used at no cost to the client and provide an informal system of support.

In a time of reduced benefits, and managed care, community based interventions such as 12-step programs are taking on more importance. The profession of social work must be aware of how to utilize and access the membership of these organizations. The value base of these programs has many similarities with those found in social work. Humanistic principles and empathetic response are practiced in social work and 12-step programs.

The theories of behavioral and cognitive, along with group psychotherapy are approaches that can be employed by social workers when working with clients that will be referred 12-step groups. Exposure to these types of therapies will prepare the client with thinking and behavior that will aid in maximizing use of 12-step programs. Positive attitudes towards the use of these program can be facilitated by social workers who incorporate recovery values into their practice.

APPENDICES

APPENDIX A

QUESTIONNAIRE

PART I

Indicate your answer to each question by using the appropriate number for each question or providing the needed information. Thank you for your cooperation.

____ 1. What is your age?

____ 2. Length of Sobriety?
1 = 1 year or less
2 = 5 years or more

____ 3. Date of Sobriety?

____ 4. Education?
1 = No high school
2 = Some high school
3 = High school graduate
4 = GED
5 = Some college
6 = College graduate
7 = Post baccalaureate

____ 5. Income level?
1 = 0 - 10,000
2 = 11,000 - 20,000
3 = 21,000 - 30,000
4 = 31,000 - 40,000
5 = 41,000 - 50,000
6 = 51,000 and above

____ 6. Type of Treatment (indicate all that apply)?
1 = No treatment
2 = Outpatient
3 = Inpatient
4 = Half-Way House

____ 7. Number of treatments?
1 = 0
2 = 1
3 = 2
4 = 3
5 = 4 or more

____ 8. Marital status?
1 = Single
2 = Married
3 = Separated
4 = Divorced
5 = Widowed
6 = Cohabitating

____ 9. Age of first use?
1 = 10 or less
2 = 11 - 15
3 = 16 - 25
4 = 26 - 35
5 = 36 or older

____ 10. Age of first treatment?
1 = 20 or less
2 = 21 - 30
3 = 31 - 40
4 = 41 - 50
5 = 51 or older

____ 11. How often do you attend 12-Step meetings?
1 = Everyday
2 = 2 to 4 times a week
3 = 5 to 7 times a week
4 = 1 time a week
5 = Less than 1 time a week

____ 12. What kind of meeting do you attend (indicate all that apply)?
1 = AA
2 = NA
3 = CA
4 = Other

____ 13. What kind of meeting do you prefer (indicate all that apply)?
1 = AA
2 = NA
3 = CA
4 = Other

PART II

Using the scale from 1 - 5 described below, please indicate on the line at the left of each statement the number that comes closet to how you feel.

1 = Strongly Agree
2 = Agree
3 = Undecided
4 = Disagree
5 = Strongly Disagree

____ 1. Your attendance at 12-Step meetings is necessary in dealing with addiction.

____ 2. Your attendance at 12-Step meetings is a major part of your recovery process.

____ 3. Your attendance at 12-Step meetings can help in your spiritual development.

____ 4. It is important to understand spirituality in order to use 12-Step meetings properly.

____ 5. Meetings should be attended even if abstinence is not maintained.

____ 6. It is important to go to one meeting a day for 90 days in a row.

____ 7. It is important to keep track of the number of meeting you attend.

____ 8. Each meeting attended is equivalent to a daily dose of medication for addiction.

____ 9. It is important to arrive to meetings early.

____ 10. It is better to not attend a meeting than to arrive late.

____ 11. It is important to talk to other meeting participants.

____ 12. It is important to socialize with other recovering people who attend 12-Step meetings.

____ 13. There is a therapeutic benefit to stating that you are an alcoholic/addict when speaking as part of a meeting.

1 = Strongly Agree
2 = Agree
3 = Undecided
4 = Disagree
5 = Strongly Disagree

____ 14. It is important to listen carefully to each person who talks during the meeting.

____ 15. It is important to plan what you will say at a meeting.

____ 16. Members of the meeting have information you need very badly.

____ 17. You can learn something from every person that speaks at a meeting.

____ 18. It is important to find a sponsor in the first 2 months of attending meetings.

____ 19. It is important to find a sponsor of the same sex.

____ 20. It is important to collect first names and phone numbers from individuals of the same sex while at meetings.

____ 21. It is important to call other recovering people who attend meetings to talk about any difficulties.

____ 22. It is important to talk about cravings during meetings.

____ 23. It is important to pitch in with cleaning at meetings by emptying ashtrays and making coffee.

____ 24. If you do not like a meeting, you should not return to one ever again.

____ 25. In treatment, it is important to be required to attend 12-Step meetings.

____ 26. It is important to attend same sex 12-Step meetings.

____ 27. It is important to attend same race 12-Step meetings.

____ 28. It is important to attend same sex and same race 12-Step meetings.

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